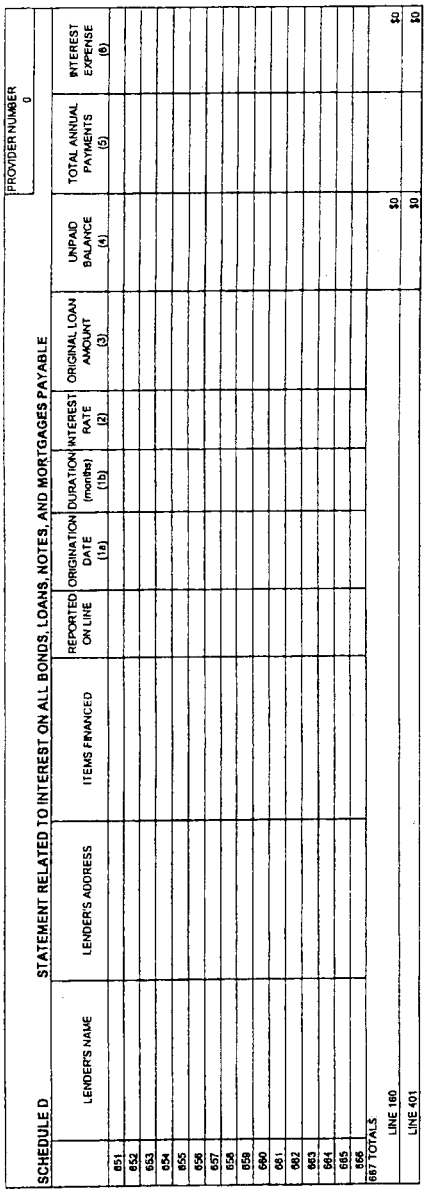

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EXCEL VE...ON

PROVIDER NUMBER
0

SCHEDULE D — STATEMENT RELATED TO INTEREST ON ALL BONDS, LOANS, NOTES, AND MORTGAGES PAYABLE

	LENDER'S NAME	LENDER'S ADDRESS	ITEMS FINANCED	REPORTED ON LINE	ORIGINATION DATE (1a)	DURATION (months) (1b)	INTEREST RATE (2)	ORIGINAL LOAN AMOUNT (3)	UNPAID BALANCE (4)	TOTAL ANNUAL PAYMENTS (5)	INTEREST EXPENSE (6)
651											
652											
653											
654											
655											
656											
657											
658											
659											
660											
661											
662											
663											
664											
665											
666											
667 TOTALS											
LINE 160									$0		$0
LINE 401									$0		$0

TOTAL OF COLUMN 6 MUST AGREE WITH THE SUM OF LINES 160 & 401. ENTRIES IN COLUMN 4 MUST AGREE WITH THE BALANCE SHEET. ATTACH A COPY OF LOAN AGREEMENTS AND AMORTIZATION SCHEDULES FOR ALL LOANS OF $5,000 OR MORE IF NOT ALREADY SUBMITTED.

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				PROVIDER NUMBER 0	
SCHEDULE E	**BALANCE SHEET**				
		BEGINNING OF PERIOD		END OF PERIOD	
ASSETS	LN#	(1)	(2)	(3)	(4)
CASH	701	[redacted]	$0	[redacted]	$0
ACCOUNTS RECEIVABLE	702	$0	[redacted]	$0	[redacted]
LESS: ALLOWANCE FOR DOUBTFUL ACCOUNT	703	$0	$0	$0	$0
INVENTORIES & SUPPLIES	704	[redacted]	$0	[redacted]	$0
ALL LOANS TO OFFICERS, OWNERS, AND RELATED PARTIES	705	[redacted]	$0	[redacted]	$0
ALL ASSETS NOT RELATED - RESIDENT CARE	706	[redacted]	$0	[redacted]	$0
ASSETS HELD FOR INVESTMENT	707	[redacted]	$0	[redacted]	$0
NURSING HOME PLANT & EQUIPMENT:					
BUILDING	708	$0	[redacted]	$0	[redacted]
LESS: ACCUMULATED DEPRECIATION	709	$0	$0	$0	$0
EQUIPMENT	710	$0	[redacted]	$0	[redacted]
LESS: ACCUMULATED DEPRECIATION	711	$0	$0	$0	$0
LEASEHOLD IMPROVEMENTS	712	$0	[redacted]	$0	[redacted]
LESS: ACCUMULATED DEPRECIATION	713	$0	$0	$0	$0
LAND	714	[redacted]	$0	[redacted]	$0
OTHER	715	[redacted]	$0	[redacted]	$0
OTHER	716	[redacted]	$0	[redacted]	$0
TOTAL ASSETS	719	[redacted]	$0	[redacted]	$0
LIABILITIES & OWNER'S EQUITY					
ACCOUNTS PAYABLE	721	[redacted]	$0	[redacted]	$0
OTHER CURRENT LIABILITIES	722	[redacted]	$0	[redacted]	$0
ALL LOANS FROM OFFICERS, OWNERS AND RELATED PARTIES	723	[redacted]	$0	[redacted]	$0
MORTGAGE PAYABLE	724	[redacted]	$0	[redacted]	$0
OTHER LONG TERM LIABILITIES	725	[redacted]	$0	[redacted]	$0
OWNER'S EQUITY OR FUND BALANCE (LIST APPROPRIATE ACCOUNTS & AMOUNTS - SEE INSTRUCTIONS)					
	727	[redacted]	$0	[redacted]	$0
	728	[redacted]	$0	[redacted]	$0
	729	[redacted]	$0	[redacted]	$0
TOTAL LIABILITIES & OWNER'S EQUITY	730	[redacted]	$0	[redacted]	$0

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		PROVIDER NUMBER 0	
SCHEDULE F BEGINNING & ENDING RESIDUAL BALANCES RECONCILIATION			
BALANCE AT BEGINNING OF PERIOD - LINE 727, 728, & 729, COLUMN 2	751		$0
INCREASES:			
REVENUE PER LINE 822, COLUMN 1	752	$0	
INVESTMENT BY OWNER	753	$0	
TRANSFERS FROM CENTRAL OFFICE	754	$0	
COMMON STOCK SOLD	755	$0	
OTHER (SPECIFY)	756	$0	
OTHER (SPECIFY)	757	$0	
TOTAL INCREASES	758		$0
DECREASES:			
EXPENSES PER SCHEDULE A, LINE 599, COLUMN 2	761	$0	
WITHDRAWAL BY OWNERS NOT IN SCHEDULE A	762	$0	
TRANSFERS TO CENTRAL OFFICE	763	$0	
DIVIDENDS PAID TO STOCKHOLDERS	764	$0	
DEPRECIATION EXPENSE IN EXCESS OF STRAIGHT LINE	765	$0	
OTHER (SPECIFY)	766	$0	
OTHER (SPECIFY)	767	$0	
TOTAL DECREASES	768		$0
BALANCE AT END OF PERIOD - LINE 727, 728, & 729, COLUMN 4	769		$0

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SCHEDULE H(1) STATEMENT OF RELATED ADULT CARE HOME INFORMATION

851 DO ANY OF THE OWNERS, RELATED PARTIES OR EMPLOYEES HAVE INTEREST, DIRECTLY OR INDIRECTLY, IN ANY OTHER ADULT CARE HOME FACILITY LOCATED IN KANSAS (EXCEPT MINOR STOCK OWNERSHIP, LESS THAN 5%, AS A PASSIVE INVESTMENT IN UNRELATED PUBLICLY HELD CORPORATION? ☐ YES ☐ NO

IF YOUR ANSWER IS NO, DO NOT COMPLETE THE REST OF THIS SCHEDULE, BUT GO TO SCHEDULE H(2). IF YOUR ANSWER IS YES, LIST BELOW ALL ADULT CARE HOME FACILITIES LOCATED IN KANSAS IN WHICH AN INTEREST EXISTS OR THAT ARE UNDER COMMON CONTROL OR OWNERSHIP. ATTACH SCHEDULE IF NECESSARY.

	(1) RELATED PROVIDER'S NAME	(2) MEDICAID PROVIDER #	(3) DESCRIBE RELATIONSHIP: OWNERSHIP/MANAGEMENT/DIRECTORS
855			
856			
857			
858			
859			
860			
861			
862			
863			
864			
865			

IF PROVIDER IS A CORPORATION, IS IT A PUBLICLY HELD CORPORATION? ☐ YES ☐ NO
IF YES, ATTACH A COPY OF THE ANNUAL REPORT TO STOCKHOLDERS AND A FORM 10-K.

SCHEDULE H(2) STATEMENT OF NON-RESIDENT RELATED ACTIVITIES

INDICATE BELOW IF YOU PARTICIPATE IN ANY NON-RESIDENT RELATED ACTIVITES AT THE FACILITY FOR WHICH YOU ARE REPORTING. ATTACH AN ADDITIONAL SCHEDULE IF NECESSARY.

	(1) NON-RESIDENT RELATED ACTIVITY?	(2) WERE ADJUSTMENTS MADE ON SCHEDULE A FOR THIS ACTIVITY?
866	CHILD DAY-CARE ☐ YES ☐ NO	☐ YES ☐ NO
867	ASSIST. LIVING/RHC ☐ YES ☐ NO	☐ YES ☐ NO
868	HOME HEALTH CARE ☐ YES ☐ NO	☐ YES ☐ NO
869	HOME DELIVERED MEALS ☐ YES ☐ NO	☐ YES ☐ NO
870	OTHER (PLEASE SPECIFY) _____	☐ YES ☐ NO
	_____	☐ YES ☐ NO
	_____	☐ YES ☐ NO

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HEDULE G REVENUE STATEMENT	LN#	REV PER BOOKS OR FED TAX RETURN (1)	ADJUSTMENT TO EXPENSE ACCOUNTS (2)	LINE NUMBER OF RELATED EXPENSE (3)
			PROVIDER NUMBER 0	
ROUTINE DAILY SERVICE:				
PRIVATE PAY RESIDENTS	801	$0		
MEDICAID RESIDENTS & PATIENT LIABILITY	802	$0		
MEDICARE RESIDENTS (PART A)	803	$0		
VETERAN ADMINISTRATION RESIDENTS	804	$0		
OTHER RESIDENTS (SPECIFY)	805	$0		
PHARMACY - DRUGS & MEDICATIONS	806	$0		
ROUTINE NURSING SUPPLIES SOLD TO PRIVATE PAY RESIDENTS	807	$0		
REVENUE FROM MEALS SOLD TO GUESTS & EMPLOYEES	808	$0	$0	
F UTY/BARBER SHOP	809	$0	$0	
RESIDENT PURCHASES/NON ROUTINE ITEMS SOLD	810	$0	$0	
PURCHASE DISCOUNTS, RETURNS, REFUNDS & ALLOWANCES	811	$0	$0	
OTHER SUPPLIES SOLD	812	$0	$0	
PROGRAM REIMBURSEMENTS & TAX CREDITS	813	$0	$0	
INVESTMENT/INTEREST INCOME	814	$0	$0	
VENDING MACHINE REVENUE	815	$0	$0	
CHILD DAY CARE INCOME	816	$0	$0	
ADULT DAY CARE/TREATMENT INCOME	817	$0		
MEDICARE PART B	818	$0		
HOME HEALTH CARE REVENUE	819	$0	$0	
NON-NURSING FACILITY RESIDENTIAL INCOME	820	$0	$0	
OTHER (SPECIFY)	821	$0	$0	
ALS	822	$0	$0	

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			PROVIDER NUMBER	0
SCHEDULE I	**FIXED ASSET, DEPRECIATION & AMORTIZATION QUESTIONNAIRE**			
901	DOES THE PROVIDER LEASE OR RENT ANY PART OF THE PHYSICAL FACILITY FROM ANY OTHER ENTITY?		☐ YES	☐ NO
902	IF YES, DO ANY OWNERS OF THE PHYSICAL FACILITY HAVE AN INTEREST, DIRECTLY OR INDIRECTLY, IN THE PROVIDER?		☐ YES	☐ NO
	IF YES, PROVIDE THE OWNERSHIP INFORMATION REQUESTED BELOW. IF NO, GO TO QUESTION 913.			
	NAME OF OWNERS OF PHYSICAL FACILITY	% OF OWNERSHIP	DESCRIBE NATURE OF RELATIONSHIP WITH PROVIDER. IF NONE, WRITE "NONE"	
905				
906				
907				
908				
909				
IF THE OWNERS ARE OTHER THAN INDIVIDUALS, READ AND FOLLOW THE INSTRUCTIONS FOR LINES 902-909 FOR COMPLEX CAPITAL STRUCTURES.				
'	HAVE COPIES OF ALL LEASE AGREEMENTS (INCLUDING AMENDMENTS) BEEN SUBMITTED WITH A PREVIOUS COST REPORT? **IF NO, SUBMIT COPIES OF DOCUMENTS NOT PREVIOUSLY SUBMITTED**		☐ YES	☐ NO
912	DOES THE LEASE CONTAIN AN OPTION TO PURCHASE THE LEASED PROPERTY?		☐ YES	☐ NO
913	IS THE PHYSICAL FACILITY OWNED BY THE PROVIDER?		☐ YES	☐ NO
914	IF OWNED, WAS THE PURCHASE AN ARMS LENGTH TRANSACTION? (ATTACH A STATEMENT OUTLINING DETAILS OF THE PURCHASE)		☐ YES	☐ NO
915	WAS THE STRAIGHT LINE DEPRECIATION METHOD USED?		☐ YES	☐ NO
	IF NO, HAVE YOU RECALCULATED THE DEPRECIATION USING THE STRAIGHT LINE METHOD AND MADE THE APPROPRIATE ADJUSTMENTS TO THE DEPRECIATION EXPENSE REPORTED ON THE EXPENSE STATEMENT?		☐ YES	☐ NO
916	DID YOU ATTACH A DETAILED DEPRECIATION SCHEDULE & WORKING TRIAL BALANCE TO THIS COST REPORT? **IF NO, SUBMIT COPIES OF DOCUMENT NOW**		☐ YES	☐ NO

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SCHEDULE J — EMPLOYEE TURNOVER REPORT

LN#	SALARY CLASSIFICATION	(2) BEGINNING # OF EMPLOYEES	(3) EMPLOYEES HIRED	(4) EMPLOYEES TERMINATED	(5) ENDING # OF EMPLOYEES	(6) HOW MANY FROM (5) ARE: FULL-TIME	(6) PART-TIME	(7) EMPLOYEES RETAINED
951	ADMINISTRATOR	0	0	0	0			
952	CO-ADMINISTRATOR	0	0	0	0			
953	OTHER ADMINISTRATIVE	0	0	0	0			
954	PLANT OPERATING	0	0	0	0			
955	DIETARY	0	0	0	0			
956	LAUNDRY	0	0	0	0			
957	HOUSEKEEPING	0	0	0	0			
958	REGISTERED NURSES	0	0	0	0			
959	LPN	0	0	0	0			
960	LICENSED M/H TECH	0	0	0	0			
961	AIDES	0	0	0	0			
962	PHYSICAL THERAPIST	0	0	0	0			
963	SPEECH THERAPIST	0	0	0	0			
964	OCCUPATIONAL THERAPIST	0	0	0	0			
965	RESPIRATORY THERAPIST	0	0	0	0			
966	PSYCH THERAPIST	0	0	0	0			
967	RECREATION THERAPIST	0	0	0	0			
968	RESIDENT ACTIVITY	0	0	0	0			
	SOCIAL WORKER	0	0	0	0			
970	MEDICAL RECORDS	0	0	0	0			
971	OTHER HEALTH CARE	0	0	0	0			
972	TOTAL ALL CLASSIFICATION	0	0	0	0	0	0	0

ATTENTION

COMPLETE THE COST REPORT ACCORDING TO THE INSTRUCTIONS AND ATTACH REQUIRED DOCUMENTS.

1. HAVE TWO COPIES OF PAGE 16 BEEN PRINTED AND SIGNED BY THE OWNER/AUTHORIZED AGENT AND THE PREPARER?
2. ARE ALL COST REPORT SCHEDULES COMPLETE?
3. ARE THE DISKETTES FOR THE COST REPORT AND THE CENSUS REPORT (AU-3902) ENCLOSED?
   PLEASE NOTE THAT YOU DO NOT NEED TO INCLUDE HARD COPIES OF THE COST REPORT
4. ARE THE FOLLOWING DOCUMENTS ATTACHED TO THE COST REPORT, IF APPLICABLE?
   (a) WORKING TRIAL BALANCE AND SUPPORTING SCHEDULES USED TO PREPARE THE COST REPORT
   (b) DEPRECIATION SCHEDULE
   (c) CENTRAL OFFICE COSTS AND ALLOCATION SCHEDULES
   (d) LOAN AGREEMENTS AND AMORTIZATION SCHEDULES (FOR LOANS OF $5,000 AND MORE)
   (e) DISKETTE OF CENSUS SHEETS (AU-3902)
   (f) DOCUMENTATION OR RESOLUTION STATING PERSON'S AUTHORITY TO SIGN DECLARATION STATEMENT IF NOT AN OWNER OR PARTNER
   (g) WORK PAPER FOR THERAPY EXPENSE ADJUSTEMENTS
   (h) COST ALLOCATION SCHEDULES FOR OTHER NON NURSING FACILITY PROGRAMS

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DECLARATION OF PREPARER:

I HAVE COMPILED THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS PREPARED FOR 0 0
FOR THE COST REPORT PERIOD BEGINNING 1/0/00
AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION, THAT I HAVE REQUESTED ALL NECESSARY AND AVAILABLE MATERIAL AND THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PREPARER'S SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

PREPARER'S ADDRESS (STREET, CITY, STATE, ZIP)	PHONE #
	FAX #

DECLARATION OF OWNER; PARTNER; OR OFFICER OF THE CORPORATION, CITY, OR COUNTY WHICH IS THE PROVIDER:

I HEREBY CERTIFY THAT I HAVE READ THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I CERTIFY THAT NO MATERIAL OR INFORMATION I HAVE ACCESS TO WOULD PRODUCE FINDINGS CONTRARY TO THOSE IN THE ACCOMPANYING COST REPORT INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS. I UNDERSTAND THAT THIS INFORMATION SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

SIGNATURE AND TITLE OF OWNER, PARTNER, OR OFFICER OF THE CORPORATION, CITY OR COUNTY WHICH IS THE PROVIDER. IF PERSON SIGNING IS NOT AN OWNER OR PARTNER, PLEASE ATTACH DOCUMENTATION OR A RESOLUTION SHOWING THEIR AUTHORITY TO SIGN. (UNLESS ONE HAD BEEN PREVIOUSLY SENT AND ON FILE)

SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

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30-10-18. Rates of reimbursement. (a) Rates for existing nursing facilities.

(1) The determination of per diem rates shall be made, at least annually, using base-year cost information submitted by the provider and retained for cost auditing and analysis.

(A) The base year utilized for cost information shall be reestablished at least once every seven years.

(B) A factor for inflation may be applied to the base-year cost information:

(2) Per diem rates shall be limited by cost centers, except where there are special level-of-care facilities approved by the United States department of health and human services. The upper payment limits shall be determined by the median in each cost center plus a percentage of the median, using base-year cost information. The percentage factor applied to the median shall be determined by the secretary.

(A) The cost centers shall be as follows:

(i) Operating;

(ii) indirect health care; and

(iii) direct health care .

(B) The property component shall consist of the real and personal property fee as specified in K.A.R. 30-10-25.

(C) The upper payment limit for the direct health care cost center shall be a statewide base limit calculated on each facility's case mix adjusted base-year costs.

(i) A facility-specific, direct health care cost center upper payment limit shall be calculated by adjusting the statewide base limit by that facility's average case mix index.

(ii) Resident assessments used to determine additional reimbursement for ventilator-dependent residents shall be excluded from the calculation of the facility's average case mix index.

(3) Each provider shall receive an adjusted rate for each quarter if there is a change from the previous quarter in the facility's average medicaid case mix index .

(4) Resident assessments that cannot be classified shall be assigned to the lowest case mix index.

(5) To establish a per diem rate for each provider, a factor for incentive may be added to the allowable per diem cost.

(6) Resident days in the rate computation.

(A) Resident days shall be determined from census information corresponding to the base-year cost information submitted by the provider.

(B) Total resident days shall be used to calculate the per diem costs used to determine the upper payment limit and rates in